REIMBURSEMENT FOR CLINIC PARTICIPATION

Michigan Department of Community Health
Children's Special Health Care Services Plan Division

1. You MUST check one
☐ **Field Clinic**
☐ **CMS Clinic**
☐ **Otology Clinic**

INSTRUCTIONS:

- Complete all information including **Item 1 above**.
- This form and signatures MUST BE ORIGINAL.
- Photocopies or stamped signatures will NOT be accepted.
- Retain the PINK copy for your records.
- Mail the WHITE and YELLOW copies along with ORIGINAL RECEIPTS to the following address:
  MDCH / PAYMENT EXCEPTIONS UNIT
  PO BOX 30688
  LANSING MI 48909

SECTION 1 - Clinic and Participating Provider Information:

2. Name of facility where services were provided.	3. Clinic Location (City)	4. Type of Clinic
5. DATE (S) Clinic was held	6. BEGIN Time First day	7. ENDING Time Last day
8. Participating Provider Name	9. Professional Specialties (if any) ☐ **Physician** ☐ **Other (specify):**	
• I certify that the information on this form is true and complete to the best of my knowledge • An ORIGINAL signature is required. • Photocopied or stamped signatures will not be accepted.	10. Provider Signature	Date Signed
11. SEND PAYMENT TO: (Name of Facility, Clinic, P.C., or Provider) 12. Mailing Address	• If payment is to a Facility, Clinic, or P.C., use FEDERAL ID No. • If payment is to an individual, use SOCIAL SECURITY No. ***Do NOT Use Both***	
City / **MI** / ZIP Code	13 a. Federal Employer ID Number	13 b. Social Security Number.

TRAVEL REIMBURSEMENT INSTRUCTIONS:

- Complete **Section 2** if travel reimbursement is being requested.
- A copy of the Clinic Registration Form must be attached.
- Reimbursement is based upon current State Standardized Travel Regulations.
- You **must** attach **original receipts** for all corresponding lodging, airline ticket, car rental, taxi, parking, and toll expenses.
- All requests for car rental reimbursement must include **justification** for the rental.

SECTION 2 - Travel Reimbursement Information:

14. DEPARTURE Date, Time, and City		
15. RETURN Date and Time		
16. **Round Trip Miles** Traveled to Clinic and Back		
17. No. of Breakfasts	No. of Lunches	No. of Dinners
18. Number of Nights of LODGING (A Receipt is required)		
19. AIRFARE (A Receipt is required)	**$**	
20. CAR RENTAL (A Receipt is required)	**$**	
21. MISC. (Parking, tolls, cabs, etc.) (A Receipt is required)	**$**	
22. Comments: *(Use additional sheets if needed)*		

AUTHORITY: Public Act 368, P.A. of 1978
COMPLETION: Is Voluntary.

For MDCH Office Use Only

Professional Services	**$**
Total Miles **X $. = **	**$**
Total Meals	**$**
Total Lodging	**$**
Airfare	**$**
Car Rental	**$**
Miscellaneous	**$**
TOTAL	**$**

Comments:

The Department of Community Health is an equal opportunity employer, services, and programs provider.

COPY DISTRIBUTION: WHITE - MDCH Accounting
YELLOW - Payment Exceptions Unit
PINK - Provider / Physician